STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center of Minneapolis	618 East 17th Street Minneapolis, MN 55404

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly manage a potential scabies outbreak in January 2026, resulting in additional rashes requiring scabies treatment for 2 of 2 residents (R73, R15) reviewed who were prescribed an antiparasitic oral medication. Further, upon discovery of R15 and R73's rashes, the facility failed to take appropriate steps to prevent the spread of possible scabies. This had the ability to affect all 85 residents residing in the care facility. In addition, the facility failed to ensure transmission-based precautions were followed, to include enhanced barrier precautions (EBP) and contact precautions for 2 of 4 residents (R24, R45) observed for proper infection control practices. Findings include: During record review it was discovered that 14 residents on the fourth floor and 2 residents on the second floor had a diagnosis of scabies in their chart dated 1/29/26. R73's annual Minimum Data Set, dated [DATE], indicated R73 was admitted to the care facility on 1/28/22 and dependent on staff for most activities of daily living (ADLs). R73's orders, dated 3/28/26, indicated an order for 2 doses of ivermectin (an antiparasitic medication used in two doses to treat scabies, among other parasitic infections) 15 milligrams (mg) to be given on 3/28/26 and 4/4/26. R73's care plan, printed 4/1/26, lacked evidence R73 was being treated for possible scabies infection and currently on transmission-based precautions. During observation and interview on 3/30/26 at 1:39 p.m., R73 stated he had been itching for weeks and was just recently started on something to help the itching, a pill he took a few days ago. On his door was a sign that indicated staff were to follow enhanced barrier precautions when in his room providing cares. R15's quarterly MDS, dated [DATE], indicated R15 was admitted to the care facility on 8/15/23 and was dependent on staff for most ADLs. R15's orders, dated 3/30/26, indicated an order for 2 doses of ivermectin 18mg to be given on 3/31/26 and 4/7/26. R15's care plan, printed 4/1/26, lacked evidence R73 was being treated for possible scabies infection and currently on transmission-based precautions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/1/26 at 12:45 p.m., R15's family member (FM)-A stated she comes to the facility every Tuesday to give R15 a shower. FM-A stated R15 has been itching his skin and on 3/24/26 the severity of the itching had increased, stating R15 was severely itching with scratch marks on his chest and buttocks. FM-A stated she spoke with the 4th floor nurse manager and registered nurse (RN)-B on 4/26/26 who suggested they go check R15 for a rash. FM-A confirmed RN-B stated R15 had a rash and had dust mites. FM-A stated that following day an evening nurse told her R15 had scabies. FM-A stated she was not provided education on what scabies was or any precautions she should take for herself. During an interview on 3/31/26 at 3:14 p.m., nurse manager and RN-B confirmed R15 and R72 were both being treated for scabies and R73 should be on contact precautions, not enhanced barrier precautions. RN-B also confirmed there was a scabies outbreak back in January on 4th and 2nd floor. During an interview on 4/1/26 at 8:44 a.m., the infection preventionist (IP), who was in her role since mid-January of this year, stated the medical director (MD) (who has since retired) diagnosed the scabies infection back in January. The IP stated the MD indicated there was no need to do diagnostic skin scrapping of any residents with rashes, to just treat it as if it was scabies and ordered ivermectin as treatment. At that time, all staff were offered ivermectin as a precaution if they wanted to take it, but the IP did not believe there was any staff who developed any symptoms of scabies or staff who took ivermectin. The IP stated she was unsure if any contact tracing was completed for residents who had discharged within 6 weeks prior to the first outbreak to ensure they were aware they were exposed to scabies and was unable to provide any documentation that would show contact tracing was complete. The IP stated the expectation for TBP was that any resident being treated for scabies was on contact precautions until 24 hours after their second dose of ivermectin. The IP stated she was aware of 2 residents who had potential scabies but believed their treatment was done and was unaware they had only received one of two doses. The IP was unaware of any education that had been done with staff regarding scabies including what to monitor for and how to prevent the spread and was not involved in any education for current staff regarding the two new cases of scabies. The IP stated she was providing some general education about scabies to new staff during orientation. The IP confirmed she was not currently doing any contact or line tracing with the current potential scabies outbreak and was not doing any look back contact tracing of who discharged in the past 6 weeks and was possibly exposed to scabies. During an interview on 4/1/26 at 9:00 a.m., the assistant director of nursing (ADON) stated the rashes started out on second floor and originally it was thought to possibly be a cleanliness issue. The ADON stated they did some education with staff and put certain nursing aides in the unit with the rashes and they cleared up. The ADON stated somebody might have had scabies, but it was treated right away. The ADON stated she was not sure exactly what had happened on 4th floor as she was the second-floor nurse manager at the time, but the 4th floor nurse manager, RN-B, told her they had scabies running ramped and still do. The ADON stated the major wave (of scabies) was over, and the floor managers were managing it now. The ADON stated she was not involved in any education regarding scabies, current or past. The ADON was aware of R15 being treated for scabies but no other residents. During an interview on 4/1/26 at 9:15 a.m., the administrator stated he believed the scabies outbreak at the end of January was mostly on second floor and the fourth floor had only one case that was treated. The administrator stated when they started getting multiple residents with a rash their MD was called in to look at the residents' skin and diagnosed the rashes as scabies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up interview on 4/1/26 at 10:03 a.m nurse manger and RN-B stated staff had completed skin checks of all residents on the 4th floor and currently only R15 and R73 have rashes and are being treated for scabies. RN-B stated she provided education to her staff on Mondays about the new cases of potential scabies, but that staff floated to all floors and there was not dedicated staff to just fourth floor where the 2 residents currently being treated for scabies reside. RN-B stated back at the end of January, during the first outbreak, two staff member had come to her with newly developed rashes and were given ivermectin as treatment. The staff were allowed to continue working during treatment. RN-B stated they had not done any contact tracing. During an interview on 4/1/26 at 10:57 a.m., Infection Control Assessment and Response (ICAR) stated any health care worker (HCW) must immediately be removed from work if they develop any symptoms, to including itching and/or a rash and be referred to their clinician and all HCWs should be educated to monitor their selves for symptoms (i.e. rash or itching). ICAR stated once a symptomatic HCW has been treated, they can come back to work but most wear a gown and gloves with all residents during cares. ICAR stated having two symptomatic HCW continuing to work could be why the facility was seeing another resurgence of scabies. ICAR further stated it would be the facility's responsibility to determine who discharged 6 weeks from the onsite of symptoms to provide them with awareness and education of possible scabies exposure. This along with a list of who is symptomatic, who is not, which staff have worked with symptomatic residents to try to find a connection or source. ICAR also confirmed having a medical record that indicated a resident was being treated for scabies would be an important part of preventing the spread if a symptomatic resident discharged or needed a higher level of care (i.e. hospitalization). During an interview on 4/2/26 licensed practical nurse (LPN)-A stated she was aware there were residents with a rash but was not sure what the treatment was. LPN-A stated she was aware to cover up (with a gown and gloves) when providing care and to wash her hands but was not provided specific education on what the rash was or to monitor herself for any symptoms. During an interview on 4/2/26 at 9:20 a.m., nursing assistant (NA)-C stated she was aware of a couple of residents with rashes but did not know what it was but was told to take precautions and wear a gown when in their rooms and to use a special soap with the residents. NA-C did not recall any specific education on monitoring herself for any rashes or itching. A facility policy titled Scabies, dated 6/2017, indicated Skin infestations by the mite Sarcoptes scabiei var. hominis are commonly known as scabies and are transmitted through direct contact with infected persons; less frequently, transmission may occur through contact with clothing or bed linens. The incubation period – the time from exposure to onset of symptoms – for primary infestation occurs as early as 10 days but is typically 4 to 6 weeks. The policy indicated if a resident is suspected of having scabies, orders would be obtained for skin scraping and the IP had authority to order skin scrapings under the direction of the MD. All suspected infected residents would be placed on contact precautions. The policy further indicated contact investigation would be completed to determine what HCW may need treatment and to provide them with education on scabies. According to the policy, all family members with exposure to scabies would be provided education on scabies, proper treatment, and encourage to obtain treatment from their physician. R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was unable to talk, was dependent on staff for all activities of daily living, received oxygen, suctioning, had a tracheostomy, a tube feeding and a ventilator. MDS included diagnoses of chronic respiratory failure, diabetes, tracheostomy, gastrostomy tube, dysphagia, autonomic nervous system disorder, and nontraumatic (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	EBP. Regarding contact precautions, IP stated any time the staff touched a resident they needed to wear a gown and gloves. IP stated staff needed to use a gown and gloves when turning and repositioning a resident and obtaining vital signs. IP stated she expected the nursing staff to wear personal protective equipment (PPE). The facility's policy titled Enhanced Barrier Precautions dated 3/28/24, indicated it was the policy of the community to protect residents and associates from the transmission of infectious diseases through use of appropriate precautions during resident care. The policy also indicated EBP expanded to the use of PPE beyond situations in which exposure to blood and body fluids was anticipated. It also referred to the use of gown and gloves during high-contact resident care activities that provided opportunities for transfers of multidrug-resistant organisms (MDROs) to staff's hands and clothing. The facility's policy titled Contact Precautions dated 9/2023, indicated It is the policy of [company] to protect residents and associates from the transmission of infectious disease through use of appropriate precautions during resident care. The policy also indicated contact precautions are used, in addition to standard precautions to prevent nosocomial spread of organisms that can be transmitted by direct resident contact or by indirect contact of environmental surfaces of contaminated equipment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 7 out of 24 residents' (R63, R24, R5, R45, R47, R65, R20) fans were kept clean to provide a safe environment for residents with tracheostomies and/or ventilators.Findings include: R63R63's annual Minimum Data Set (MDS) dated [DATE], indicated R63 was unable to speak, had moderately impaired decision making, and depended on staff members for all activities of daily living (ADLs). MDS indicated diagnoses of cardiorespiratory debility, tracheostomy, had a ventilator, and received oxygen and had a tube feeding. During observation on 3/30/26 at 5:35 p.m., R63 was sleeping in bed with her mouth open. A fan mounted on a wall was blowing air and there was dust accumulated on the grid. The fan was stopped, and dust was present on the fan blades. R63 woke during the visit but she was unable to answer questions. R24R24's quarterly MDS dated [DATE], indicated diagnosis of cardiorespiratory debility, unable to talk, had a tracheostomy, a ventilator and a gastrostomy tube. MDS indicated R24 was dependent on staff members for ADLs. During observation on 3/30/36 at 5:50 p.m., R24 was awake, lying in bed in a supine position. R24 had a tracheostomy tube, a ventilator and a tube feeding. A fan mounted on the wall was on and dust had accumulated on the grid. The fan was stopped, and the fan's blades were dusty. R5R5's quarterly MDS dated [DATE], indicated R5 was cognitively intact, needed moderate assistance with bathing, was dependent to put on footwear, needed set up with personal and oral hygiene. The MDS indicated diagnoses of traumatic brain injury, chronic obstructive pulmonary disease, had a tracheostomy which needed suctioning. During observation and interview on 3/30/26 at 1:42 p.m., R5 stated the fan was dusty and added, the housekeepers clean the fan, but not very often. R45R45's quarterly MDS dated [DATE] indicated R45 was nonverbal, had a diagnosis of cardiorespiratory debility, and was dependent on staff for all his ADLs. R45's face sheet dated 4/3/26, indicated diagnoses of unspecified intellectual disabilities, chronic respiratory failure with hypoxia, epilepsy, dependence on ventilator, tracheostomy, gastrostomy tube, and dysphagia. During observation on 3/30/26 at 5:48 p.m., R45 was in bed, and he had a tracheostomy, a ventilator and a tube feeding. A fan mounted on the wall had dust accumulated on the grid and its blades. R47R47's 5-day MDS dated [DATE], indicated R47 had moderate impaired decision making, was unable to talk, and depended on staff for all ADLs. The MDS indicated diagnoses of progressive neurological condition, chronic respiratory failure, dependence on ventilator, tracheostomy and had a tube feeding. During observation on 3/30/26 at 6 p.m., R47 was in bed, did not respond to questions, and his mouth was wide open. R47 had a tracheostomy, was on a ventilator and a tube feeding. A wall-mounted fan was running and covered with dust. R20R20's quarterly MDS dated [DATE] indicated R20 was cognitively intact, was dependent on bathing, dressing and needed substantial assistance with dressing, and personal hygiene. R20's MDS included diagnoses of cardiorespiratory debility, oropharyngeal dysphagia, dependence on ventilator, and obstructive sleep apnea. MDS also indicated R20 had a tracheostomy, ventilator, received suctioning and had a tube feeding. During observation on 3/30/26 at 6:45 p.m., R20 was in his room, he had a tracheostomy, had a ventilator and had a tube feeding. A fan mounted on a wall was on, and dust was visible on the fan's grid. R20 said yeah it is dirty, I am not sure when or who cleans the fan. R65R65's quarterly MDS dated [DATE], indicated R65 was unable to speak and was dependent on staff for all ADLs. MDS indicated diagnoses of amyotrophic lateral sclerosis, anxiety, depression, respiratory failure, gastrostomy, oropharyngeal dysphagia, dependence on ventilator, and progressive bulbar palsy. MDS also indicated R65 received oxygen, suctioning, tube feeding, and tracheostomy cares. During observation on 4/1/26 at 12:05 p.m., R65 was not in his room. A fan mounted on a wall was on, and the fan's grid was covered with dust. When the fan was turned off there was also dust on the fan's blades. During interview on 4/1/26 at 1:43 p.m., registered nurse (RN)-A verified the fans observed in the residents' (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room were dusty. RN stated the fans should be cleaned to prevent allergies and/or infections. RN-A added, especially in the rooms with residents with respiratory problems. During interview on 4/1/26 at 1:51 p.m., nursing assistant (NA)-A stated, if the rooms needed to be clean, she would notify the housekeepers. NA-A stated she didn't pay attention to the fans and added my priority is taking care of my patients. During interview on 4/2/26 at 8:31 a.m., housekeeper aid (HA)-A stated he cleaned the fans once a week. During interview on 4/2/26 at 8:34 a.m., the maintenance director (MD) indicated his department had a cleaning schedule. MD stated it was on a template, but he wasn't sure if the fans were included on the template. MD stated he did monthly rounds to check every room, but the fans were usually on, and it's difficult to determine if they were dirty when they are on. MD stated his expectation will be to check the fans every week and at least clean them monthly. During interview on 4/2/26 at 1:34 p.m., RN-D stated the fans in residents' rooms should be cleaned to prevent dust blowing in their room. RN-D added, especially in the rooms of residents with tracheostomies and ventilators to minimize the risk of further respiratory problems. Facility's procedure titled Resident Rooms-Routine Cleaning dated 11/2025, indicated maintaining clean and attractive surroundings without disrupting resident care. The undated Room Survey form included observing the room environment and furniture, including fans to ensure they were cleaned and functional.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a significant medication error was reported to the State Agency (SA) within 24 hours for 1 of 1 resident (R15) reviewed who received 1/10th of the prescribed dose of seizure prevention medication twice daily for 24 of days.Findings include:R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated R15 had severe cognitive impairment, depended on staff for all activities of daily living, and had a diagnosis of hemiplegia and hemiparesis following cerebral infraction affecting the right dominant side. Other diagnoses included hypertension, diabetes, non-Alzheimer's dementia, seizures, and depression.R15's progress notes included:- 10/20/25 note at 4:16 p.m., indicated at 1:00 p.m., a nursing assistant (NA) reported to the nurse on duty R15 was shaking. Nurse indicated R15 was alert, and his right upper and lower extremities were shaking. Vs were obtained. R15's whole body started to shake, 911 was called, and R15 was taken to a local hospital at 1:25 p.m.-10/21/25 note indicated R15 returned at 11:40 p.m., with new order of Keppra 1000 milligrams (mg) twice a day. Order was faxed to pharmacy. R15 was alert, had dinner, denied pain and SOB.-10/21/25 note indicated the facility contacted the pharmacy and were informed the medication would be delivered next day by 9 a.m.R15's October's medication administration record (MAR) included an order dated 10/20/25 for levetiracetam 100 mg/ml, administer 100 mg orally twice a day. R15 received the first dose on 10/21/25.-10/31/25 note indicated R15 had a 60 second, jerking seizure at 9:30 p.m. The note indicated no other seizures were noted for the rest of the shift. A message was left for R15's brother, and the provider was notified.-11/13/25 note indicated at approximately 10:00 a.m., a housekeeper reported R15 was shaking in his room. R15 was sitting in his wheelchair and was experiencing a violent seizures. R15 was unable to articulate but he exhibited signs and symptoms of both pain and discomfort through his facial expressions and verbal cues. The seizures were recurrent, occurring in succession. Facility updated the provider and called R15's daughter. -11/13/25 note indicated at 10:56 a.m., the paramedics took R15 to the ER and his daughter went with them. -11/13/25 note indicated R15 return to the facility at 10:00 p.m. The hospital visit summary indicated lab work was negative for infection, lactate level was elevated, which may be consistent with the possible seizure episode. Daughter stated the EEG did not show definitive evidence of seizure activity. R15 also needed to have a neurologist follow-up appointment.R15's Active Orders dated 4/3/26 indicated an order for levetiracetam (anti-seizure medication) also known as Keppra. The Keppra order dated 11/14/25, indicated: levetiracetam solution 100 milligrams (mg) /milliliter (ml), 1000mg oral twice a day.R15's Customer Concern form dated 11/17/25, indicated a pharmacy concern related to a transcription dosage deviation. The concern form included a findings section which indicated on 10/20/25, R15 experienced severe seizures and was sent to the emergency department (ER). R15 was discharged back to the facility with a new order for Keppra 1000 mg orally twice a day. On 11/13/25, R15 experienced seizures, was evaluated in the ER and returned to the facility the same day. On 11/17/26 the nurse practitioner discovered R15 had been receiving 100 mg of Keppra twice a day instead of 1000 mg twice a day. R15's Event Report dated 11/19/26, identified as a Safety Event-Medication Error indicated the event occurred on 10/20/25. The error began on 10/20/25 and ended on 11/14/25. It was described as a medication error, wrong dose- too little. The report indicated the following adverse extrapyramidal drug reactions- eg.- various combinations of tremors, postural unsteadiness, lack of slowness of movement, cogwheel rigidity, expressionless face, drooling, infrequent blinking, shuffling gate, decreased arm swing, and rigidity of muscles in the limbs, neck, and trunk.- 11/19/25 note indicated R15's brother was informed about Keppra medication error, whereby resident was being given a less dosage than was prescribed. Family did not verbalize any concerns about the low dose. The note indicated on 11/14/25, the nurse practitioner (NP) discovered the Keppra dose needed (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be increased to 10 ml, the changes were done immediately, and R15 had not had any seizures since. Lab work was ordered, and medications were faxed over by the NP. R15's November's MAR indicated R15 received 100 mg of Levitra twice a day until 11/13/25. On 11/14/25 R15 started to receive 1000 mg of Levitra twice a day. A provider note dated 11/14/25 indicated, noted that dose was wrong.according to the ED report he [R15] should have been getting 1000 mg twice a day and he is getting the liquid at the facility, but he is only getting 100 mg twice a day so that order was changed -this possibly is why he was having breakthrough seizures. During interview on 4/2/26 at 3:05 p.m., health unit coordinator (HUC) stated the nurses write the orders, then she transcribed them into the computer and gave back the order to the nurse to double check the accuracy of the order. HUC stated all orders were always checked twice. During interview on 4/2/26 at 3:00 p.m., licensed practical nurse (LPN)-A stated when a resident returned from a hospital, the nurse faxed the orders to the pharmacy. RN-E stated the nurses get the orders and the HUC or a nurse entered the orders on the computer. Once the orders were entered into the computer, the orders were checked by two people. During interview on 4/2/26 at 3:10 p.m., RN-E stated the nurses get physician orders, HUC entered the orders in the computer, and nurses verified the orders. RN-E added all orders were double checked. RN-E stated she knew she had to report medications errors and complete paperwork following facility policy. During interview on 4/2/26 at 3:08 p.m., nurse manager RN-B stated on 10/20/25 R15 had seizures and was to the hospital for evaluation. R15 returned to the facility the same day with orders for Keppra 1000 mg twice a day. On 10/20/25 the Keppra order was transcribed by a nurse, but instead of 1000 mg the order was transcribed as 100 mg twice a day. R15 received 100 mg twice a day from 10/21/25 through 11/13/25. RN-B stated, on 11/13/26 R15 had another seizure, he was sent to the hospital for evaluation and returned the same day without new orders. R15 was to remain on 1000 mg of Keppra twice a day. On 11/14/25 RN-B received a call from R15's NP. NP was reviewing R15's 11/13/25 visit to the ER and realized a medication error had been made. RN-B received a verbal order for Keppra 1000 mg twice a day. RN-B stated she reported the medication error to the interim director of nursing and called the family. RN-B stated she didn't know if the medication error was reported to the SA. During interview on 4/2/26 at 3:02 p.m., the administrator and the company's regional nurse indicated the transcription error was not reported because it was not clear this caused harm to R15, so the error was internally fixed and R15 was monitored for further seizure activity.Facility's policy titled Medication Errors dated 8/31/23, indicated when a medication error was made in the preparation or administration of a drug or biological, the licensed staff provides any necessary immediate care, and notifies the attending provider and resident or resident representative.

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	245266	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center of Minneapolis	618 East 17th Street Minneapolis, MN 55404

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide a bed hold notice for 1 of 1 residents (R12) reviewed for hospitalization.Findings include:R12's quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, indicated R12 had moderately impaired cognition with no hallucinations, delusions or behaviors.During an interview and observation on 3/30/26 at 12:49 p.m., R12 was observed lying in bed. R12 responded to questions with yes or no answers.R12's face sheet, dated 4/2/26, indicated R12 had an identified emergency contact and who would also receive statements.R12's census log, printed 4/2/26, indicated R12 was on hospital leave from 2/22/26 and returned on 2/27/26.R12's progress notes, dated 2/15/26 to 2/28/26, were reviewed and identified the following:-2/22/26 at 11:22 p.m.: resident was sent to the hospital for not responding well. Supervisor, resident's spouse, and on-call provider was notified.-2/23/26 at 2:42 a.m.: facility called to follow up with the hospital who continued to determine if resident was going to be admitted or discharged .-2/23/26 at 6:11 a.m.: facility received a call from hospital stating resident will be admitted for continued management and monitoring.-2/24/26 at 4:24 p.m.: facility called to get an update on resident.-2/27/26 at 2:23 p.m.: resident was escorted by two attended via stretcher at 11:50 am, awake and pleasant. Will update incoming shift. The progress notes lacked any indication a bed hold was completed prior to being sent to the hospital, or whether a bed hold was sent to the hospital after resident was transferred.R12's medical record was reviewed and lacked evidence a bed hold notice was provided for 2/22/26 hospitalization either in electronic medical record or in paper chart.During an interview on 4/2/26 at 12:32 p.m., registered nurse (RN)-G stated when a resident transferred to a hospital, the nurse obtained a bed hold which was documented in the electronic medical record. The forms were printed out for the resident to sign, if they were able, and then uploaded once signed. RN-G stated if the resident wasn't able to sign then they talked to the family.During an interview on 4/2/26 on 12:38 p.m., assistant director of nursing (ADON)-B stated the expectation was nurses on the floor would obtain the bed hold when the resident transferred to the hospital. ADON-B stated the form would be signed and uploaded into the electronic medical record. ADON-B could not locate the bed hold for R12's hospitalization for 2/22/26 to 2/27/26, and would have expected it to be done. ADON-B stated she would follow up on the bed hold to see if she could locate it. During an interview on 4/2/26 at 12:48 p.m., ADON/registered nurse (RN)-D stated they would expect nurses to complete the bed holds when a resident transferred to the hospital as if a resident wants their bed held, and it was important to do this. RN-D was unable to locate a completed bed hold for R12's 2/22/26 hospitalization.During an interview on 4/3/26 at 10:05 a.m., administrator stated there was no further documentation for R12's bed hold to provide.A facility policy titled Bed Hold, reviewed 10/23, indicated Prior to or at the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident, responsible party, or legal representative written notice which restates and specifies the duration of the bed hold policy. If that is not possible due to extenuating circumstances (i.e. resident has gone to the hospital for an emergency), the Facility must communicate the information by telephone with the resident or responsible party/legal representative, and follow up by mailing the authorization/request form. A signature is not required on the written notice form, as long as the notice is issued to the resident or representative. If the notice is not signed, write the resident's name and how the notice was issued to the resident (e.g., resident unable to sign, or verbal consent by phone given by [name].

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (R88) reviewed for a closed record.Findings include:R88 was admitted to the facility on [DATE] with a diagnosis of aftercare following left knee joint replacement. During R88's stay at the facility, she received therapy services and was discharged from the facility to her home.R88's discharge MDS dated [DATE] indicated, R88 was discharged to a short-term general hospital.R88's electronic medical record (EMR) included a progress note dated 2/9/26 at 3:33 p.m. The progress note indicated R88 was discharged at 11:00 a.m. to her home with her sister. R88's sister provided transportation. Note identified a local home health agency would provide home services. Medication prescriptions were faxed to a local pharmacy, and R88 was discharged with medications as ordered. R88's Discharge Plan of Care indicated R88 returned home on 2/9/26.During interview on 4/2/26 at 9:29 a.m., corporate MDS/registered nurse (CMDS) verified, the R88's discharge MDS indicated R88 was discharged to a hospital. CMDS stated the facility's MDS nurse made a coding error, CMDS added she will make a MDS modification.Requested a MDS policy but was not provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who were on transmission-based precautions for potential scabies had a documented diagnosis and care plan to ensure staff and any potential future care facilities were aware to help prevent the spread of scabies for 2 of 2 residents (R15 and R73) reviewed who were currently being treated for scabies. In addition, the facility failed to assure a skin care plan was updated to accurately reflect the skin problems for 1 of 1 resident (R24) reviewed for pressure areas.Findings include:R73's annual Minimum Data Set, dated [DATE], indicated R73 was admitted to the care facility on 1/28/22, and dependent on staff for most activities of daily living (ADLs).R73's orders dated 3/28/26, included an order for 2 doses of ivermectin (an antiparasitic medication used in two doses to treat scabies, among other parasitic infections) 15 milligrams (mg) to be given on 3/28/26 and 4/4/26 for dermatitis.R73's care plan, printed 4/1/26, lacked evidence R73 was being treated for possible scabies infection and currently on transmission-based precautions.During observation and interview on 3/30/26 at 1:39 p.m., R73 stated he had been itching for weeks and was just recently started on something to help the itching, a pill he took a few days ago. On his door was a sign that indicated staff were to follow enhanced barrier precautions when in his room providing cares.R15's quarterly MDS, dated [DATE], indicated R15 was admitted to the care facility on 8/15/23, and was dependent on staff for most ADLs.R15's orders, dated 3/30/26, included an order for 2 doses of ivermectin 18 mg to be given on 3/31/26 and 4/7/26.R15's care plan, printed 4/1/26, lacked evidence R73 was being treated for possible scabies infection and currently on transmission-based precautions.During an interview on 3/31/26 at 3:14 p.m., nurse manager and RN-B confirmed R15 and R72 were both being treated for scabies, not dermatitis and was not sure why ivermectin was written for a diagnosis of dermatitis. RN-B also stated R73 should be on contact precautions, not enhanced barrier precautions.During a follow up interview on 4/1/26 at 10:03 a.m., RN-B confirmed R15's and R73's electronic medical record lacked any evidence they were being treated for scabies and should.During an interview on 4/1/26 at 10:57 a.m., Infection Control Assessment and Response (ICAR) stated having a medical record that indicated a resident was being treated for scabies would be an important part of preventing the spread if a symptomatic resident discharged or needed a higher level of care (i.e. hospitalization). A facility policy titled Comprehensive Assessments and Care Planning, dated 2/26/26, indicated a comprehensive, person-centered interdisciplinary care assessment of the residents' condition is used to develop consistent quality care and must accurately reflect the residents' status to include disease diagnosis and health conditions.R24R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was unable to talk, and was dependent on staff members for all activities of daily living, turning, repositioning, and transfers. MDS indicated R24 was at risk of developing pressure areas, had pressure areas and open lesions, and had pressure-reducing devices for his chair and bed.R24's Face Sheet dated 4/1/26, indicated R24 was admitted to facility on 11/19/24. The face sheet indicated diagnoses of chronic respiratory failure, nontraumatic subdural hemorrhage, dependence on respirator, tracheostomy, gastrostomy, dysarthria following cerebral infarction, moderate protein-calorie malnutrition, pressure areas and iron deficiency anemia.R24's Active Orders report dated 4/1/26, included the following orders related to resident's skin problems:Pro-stat (concentrated, liquid protein medical food designed to manage pressure injuries, wounds and protein-energy malnutrition).Cares for dry blisters with a diagnosis of Bullous Pemphigus (large fluid-filled blisters)Wound care for his left lateral distal leg pressure area.Wound care for his left lateral proximal leg pressure area.Osmolyte 1.2 60 milliliters (ml) per hour for 20 hours via gastric tube.Eucerin cream for dry skin.Wound care for left heelWound care for pressure area on left ear.Wound care for pressure area under the left side where trach ties were secured.Weekly skin checks on bath days.R24's care plan report dated 4/1/25, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included a care plan titled Alteration in Skin Integrity related to diagnoses of diabetes and decreased mobility. The care plan had three sections: problem, goal and approach.The Problem section included the following information:Problem dated 11/20/24, indicated R24 had several pressure areas on admission, located on his coccyx, right scapula, right thigh and left thumb.Problem was updated on 4/10/25, and indicated R24 still had a pressure area on his coccyx, left ear and right scapula.The problem section was last updated on 7/8/25, and indicated pressure areas on his coccyx and right scapula.The Goal section dated 11/20/24 indicated resident's skin alteration will heal without infection.The Approach section included the following information:The approach section, dated 11/20/24 directed staff toEncourage adequate nutrition and hydration.Encourage adequate nutritionMonitor for indication of infection, contact MD if present.Physical therapy/occupational therapy for screening as appropriate.Treatment/dressing per MD orders.Turning and repositioning every 2-3 hours and as needed. The approach section dated 9/26/25 directed staff,Use pillows for repositioning him off bony prominences including his coccyx, scapula and other areas prone to breakdown.Use specialty mattress and float his heels or use protectors.Positioning for comfort.The Care Plan report indicated the skin care plan was last reviewed/revised on 11/25/25 at 6:07 pm. The care plan lacked interventions to address R24's ongoing skin changes.R24's Wound Care visit report dated 3/19/26, indicated R24 had a stage 2 pressure area on his left lateral distal leg, a stage 2 left lateral proximal leg, a stage 2 pressure area on his left ear and a right pressure area under the left side of the tracheostomy plastic part.R24's current physician orders included wound care orders for the pressure areas listed above.R24's Skin Assessments dated 3/23/26, and 3/30/26, indicated R24's skin was clean, dry and intact.During interview on 4/1/26 at 7:54 a.m., RN-A stated, R24 had several pressure areas and was seen weekly by the wound care specialist. RN-A stated the nurses were responsible for obtaining or receiving new wound care orders, but the care plan was updated by the nurse manager.During interview on 4/2/26 at 1:34 p.m., RN- B stated the care plans were updated as needed to reflect resident's medical changes. RN-B added the care plans were reviewed and updated when a MDS assessment was completed. RN-B verified the last time R24's approach section of the care plan was updated, was done on 9/26/25. Between 9/26/25 and 4/1/26 R24 wounds and wound care orders were changed but the care plan was not updated. RN-B stated she expected the care plans would be accurate and reflected resident's problems, goals, and interventions.Facility's policy titled Comprehensive assessment and Care Planning dated 2/26/26, indicated a registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals, and sign and certify that the assessment was completed. The assessment must accurately reflect the residents' status. The policy also indicated the facility should use the results of the assessment to develop, review and revise the residents' person-centered comprehensive care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to monitor for signs and symptoms of bleeding and failed to follow up with provider to reinstate an anticoagulant medication for 1 of 1 resident (R31) reviewed for change in condition. In addition, the facility failed to obtain laboratory results and update the primary provider in a timely manner to initiate treatment for a urinary infection for 1 of 1 resident (R31) reviewed for urinary infection.Findings include:F31's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R31 was comatose, depended on staff members for activities of daily living, and received food and medications through a tube feeding. MDS indicated R31 received oxygen, had a tracheostomy, received oral suctioning, and had a gastrostomy tube. MDS indicated diagnoses of stroke, atrial fibrillation, heart failure, hypertension, nontraumatic intracerebral hemorrhage, acute and chronic respiratory failure, persistent vegetative state, autonomic dysreflexia and unspecified convulsions.AnticoagulantR31's March Medication Administration Record (MAR) indicated R31 received 5 mg of Eliquis twice a day from 3/1/26 through the morning dose on 3/9/26.R31's progress notes indicated3/9/26 at 2:02 a.m., R31's urine was dark red. The nurse contacted on-call provider to report R31's status. On-call nurse practitioner (NP) directed staff to continue to monitor and wait until the next day. On-call NP ordered to continue Eliquis as ordered due to risk of clotting.3/9/26 at 3:49 p.m. R31's NP was updated about hematuria (blood in urine), and she held the Eliquis. 3/9/26 at 10:59 p.m. note indicated R31's brief was changed 3 times, still had blood in the urine, and staff were waiting for lab results.3/10/26 at 11:00 p.m. note indicated hematuria was noted again and a urine sample was collected. A fax request was sent to lab to be picked up the next day.3/17/26 at 10:47 a.m. note indicated provider will hold/discontinue Eliquis because of bleeding of the resident.3/24/26 at 3:45 p.m. note indicated daughter wanted Eliquis restarted. NP was contacted and she restarted previous Eliquis order. R31 receive the first dose in the morning.R31's Active Orders report dated 4/1/26 included an order for Eliquis 5 milligrams (mg) twice a day. This order was dated 3/25/26.During interview on 3/31/26 at 11:17 a.m., family member (FM)-A stated on 3/8/26, she noted blood in R31's urine and reported it to the nurse on duty. On 3/9/26 she was informed R31's Eliquis was placed on hold. FM-A stated she visited R31 every day and helped staff to provide cares for her, including changing her brief. FM-A stated after 3/8/26, she did not see any blood in R31's urine, and the staff did not report further bleeding episodes to her. On 3/24/26, FM-A visited R31 while nurse on duty administered the morning medications. R31's Eliquis was not administered. FM-A talked to the nurse and found out the Eliquis had been on hold since 3/9/26. FM-A stated she asked nurse on duty to call the NP and asked her to restart the medication. The nurse contacted the NP, and the medication was restarted on 3/24/26.During interview on 4/2/26 at 12:50 p.m., assistant director of nursing (ADON) stated the Eliquis order on the MAR was written as 'hold/discontinued' because their computer program discontinues any medication placed on 'hold'. ADON verified she contacted the NP and wrote the 3/17/26 progress note. The 3/17/26 indicated provider will hold/discontinue Eliquis because of bleeding of the resident. ADON verified the electronic medical record (EMR) lacked documentation about further bleeding monitoring after 3/10/26. ADON stated the facility failed to clarify the order to hold the Eliquis. ADON stated her expectation was for nursing staff to monitor, document bleeding and update the NP. ADON added, the order also needed to include directions to monitor for bleeding, and when to update the NP on a pre-determined date. Urinary infection, R31's progress notes indicated,3/9/26 at 2:02 a.m., R31's urine was dark red, and a urine sample was collected. Contacted on-call provider to report R31's status. On-call nurse practitioner (NP) directed staff not to send the urine sample to the laboratory, continue to monitor, and wait until the next day. On-call NP ordered to continue Eliquis as ordered due to risk of clotting.3/9/26 at 3:49 p.m. R31's NP was updated about hematuria (blood in urine), and she ordered a urinalysis, and held R31's Eliquis. Sample was sent to the laboratory.3/9/26 at 10:59 p.m. note, indicated R31's brief was changed 3 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times, still had blood in the urine, and staff were waiting for lab results.3/10/26 at 12:46 p.m. note indicated the urine sample was cancelled by the laboratory due to wrong spelling of resident's name. Laboratory advised them to send a new sample.3/10/26 at 11:00 p.m. note indicated hematuria was noted again and a urine sample was collected. The staff faxed the lab to request the urine sample to be picked up the next day.3/11/26 at 12:58 p.m. note indicated the urinalysis sample was picked up by the lab.3/11/26 at 3:11 p.m., indicated the staff left a message to NP regarding the urinalysis lab report.3/11/26 at 3:53 p.m. note indicated the NP called back, gave no new orders and instructed staff to wait for urine culture results since the results were negative for nitrate.R31's progress notes lacked documentation about urine culture results or contacting the provider to obtain orders for an antibiotic.R31's laboratory culture results faxed to facility on 3/15/256 indicated growth of >100,000 CFU/ml Escherichia coli and >100,000 CFU/ml Proteus mirabilis.R31's March MAR did not include documentation of resident receiving an antibiotic. During interview on 3/31/27 at 11:17 a.m., FM-A stated one of the symptoms R31 displayed when she had a urinary infection was the presence of blood in the urine. FM-A asked the nurse on duty to call the provider and to request laboratory work to check for a urinary infection. FM-A stated the nurse contacted the primary provider and a urine sample was going to be picked up on 3/9/26. On 3/10/26 FM-A was informed a new urine sample needed to be collected because R31's name was not properly spelled. The second sample was collected on 3/11/26. On 3/12/26 the nurse told her the urinalysis was negative. FM-A stated on 3/13, 3/14, 3/15 and 3/16 she asked the staff for the urine culture results. On 3/17/26, FM-A stated R31 had a thick light brown-amber discharge in her brief. FM-A called the nurse on duty and asked her if the culture results were back from the laboratory. FM-A stated on 3/18/26, the nurse on duty told her R31 was started on an antibiotic for a urinary infection. FM-A stated, apparently the staff contacted the provider on 3/17/26. FM-A stated she was upset because nobody called her to inform her about the new orders. Later, FM-A received a copy of the laboratory reports and noted the culture results were faxed to the facility on 3/15/26. FM-A stated she was unable to understand why the nursing staff waited until she asked about the results to do something. FM-A stated, I am upset thinking she [R31] was uncomfortable with a urinary infection, and she was unable to communicate her discomfort.During interview on 4/2/26 at 8:46 a.m., registered nurse (RN)-H stated, when a urine sample was collected it should be accurately labeled with residents' name, date, time, and resident's medical record number. RN-H stated the laboratory usually collected samples by 3 p.m. on their regular days, and as needed if a lab test needs to be done as soon as possible.During interview on 4/2/26 on 4/2/26 at 8:51 a.m., health unit coordinator (HUC) stated the nurse collected urine samples, completed a lab form and placed it in the laboratory binder. HUC stated the nurses needed to make sure the sample was collected. If a sample was not collected, they needed to contact the lab. HUC stated the laboratory faxed the results to the appropriate nurses' station.During interview on 4/2/26 at 9:06 p.m., nurse manager/RN-B stated after the laboratory collected a urine sample, the expectation was for the nurses to look for the results. If the results were not faxed by the end of their shift, the nurse needed to call the laboratory and request the results. RN-B added if the results were not available, the next shift needed to follow up. Once the results were available, the nurses needed to call the doctors with the results.During interview on 4/2/26 at 12:29 p.m., assistant director of nursing (ADON) stated R31's urine sample was picked up on 3/9/26, but her name was spelled incorrectly. ADON stated on 3/10/26, the family asked about the lab results. A new sample was obtained and was sent to the lab. ADON stated on 3/15/26, the lab faxed the results, but facility staff called the NP on 3/18/26, and obtained orders for an antibiotic. ADON added the results should have been called as soon as they were available. ADON stated the nurses took too long to call the NP, and R31's infection could have worsened.During interview on 4/2/26 on 4/2/26 at 1:34 p.m. RN-D, who was covering for a vacant nurse manager position, stated lab results should be called to the providers as soon as they become available. RN-D stated she didn't see the results, didn't have an explanation for the delay, and had no other information.Facility's policy titled Change in Condition, Resident (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to monitor for orthostasis, a common side effect of antipsychotic medication, for 2 of 5 (R2 and R79) residents reviewed for unnecessary medications who also had a history of falls. Findings include:A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, All antipsychotics carry some risk of orthostatic hypotension . [which can] lead to dizziness, syncope, falls . it should be evaluated by both history and measurement . Risk factors include systemic diseases causing autonomic instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age.R79R79's annual Minimum Data Set (MDS), dated [DATE], indicated R79 was cognitively intact and independent with most activities of daily living (ADLs). The MDS further indicated R79 had taken antipsychotic medications during the look-back period. R79'd orders indicated an order for lurasidone (an atypical antipsychotic medication), dated 3/12/25, 40 milligrams (mg) once a day for schizophrenia, and risperidone (an atypical antipsychotic medication), dated 3/31/26, 5mg twice a day for bipolar. R79's electronic medical record (EMR) lacked any evidence orthostatic blood pressure was being monitored. R79's progress notes, dated 3/24/26, directed staff to provide R79 with a water pitcher at the beginning of each shift to help manage her blood pressure. R79's progress note, dated 3/17/26, indicated staff found R79 sitting on the bathroom floor, stating she lowered herself to the floor after she felt dizzy. R79's progress note, dated 2/5/26 indicated staff met with R79 related to a recent fall. R79's progress note, dated 1/22/26, R79 was found on the floor outside the smoking area. R79's progress note, dated 1/1/26, R79 fell coming inside from the smoking area. During an interview on 4/2/26 at 9:12 a.m., R79 stated she feels dizzy at times which causes her to fall. During an interview on 4/2/26 at 9:20 a.m., stated R79 had falls once and awhile and was able to ambulate independently around the facility and would call staff for help if she felt unsafe. R2 R2's significant change MDS, dated [DATE], indicated R2 was cognitively intact and dependent on staff for most ADLs. The MDS further indicated R2 took antipsychotic medications during the look-back period. R2's orders, dated 2/5/26, indicated an order for clozapine (an atypical antipsychotic medication) 300 mg at bedtime for paranoid schizophrenia. R2's electronic medical record (EMR) lacked any evidence orthostatic blood pressure was being monitored. During an interview on 4/2/26 at 11:10 a.m., clinical manager and registered nurse (RN)-B stated R2 had a fall with major injury and was currently only walking with physical therapy and was pivot transferring with staff. RN-B further stated R79 would fall if her blood pressure dropped, causing her to get dizzy. RN-B confirmed that neither R2 nor R79 had care planned or ordered interventions to monitor orthostatic blood pressure, stating it would be a good idea for R79 with her history of falls and dizziness. During an interview on 4/2/26 at 2:10 p.m., the regional director stated it was expected that orthostatic blood pressure be monitored monthly for residents on antipsychotic medications. A facility policy titled Psychotropic Medication use, dated 9/7/23, indicated medication side effects to be monitored (i.e. orthostatic blood pressure.)